Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125063	A. BUILDING: _____ B. WING _____	10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
15 CRAIGSIDE	15 CRAIGSIDE PLACE HONOLULU, HI 96817

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 000	Initial Comments A licensure survey was conducted by the State Agency from 10/09/19 through 10/11/19. The facility was found not to be in substantial compliance with Chapter 94.1, Nursing Faciilites. The census at entrance was 40 residents. An incident report (HI00007545) was investigated during the survey. There was no deficient practice related to the facility reported inicdent.	4 000		
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on observations, record review and interview with facility staff, the facility failed to identify an accident risk to avoid an accident while wheeling/pushing a resident in the wheelchair without foot rests for one (Resident 14) of one residents sampled for accident hazards Findings include:	4 136	15 Craigside is committed to ensuring that residents remain safe and attain or maintain the highest practicable quality of life. On 11/7/2019 the Interdisciplinary team (IDT) reviewed the potential for injury of the resident identified in the findings.	11/15/19

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125063	A. BUILDING: _____ B. WING _____	10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
15 CRAIGSIDE	15 CRAIGSIDE PLACE HONOLULU, HI 96817

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 136	Continued From page 1 Resident (R)14 was admitted to the facility on 04/11/16 from an acute facility. R14's diagnoses include: encounter for palliative care; Alzheimer's disease with late onset; dementia, other diseases classified elsewhere with behavioral disturbance; history of falling; and major depressive disorder, single episode, unspecified. On 10/09/19 during lunch observation, R14 was found to self-propel in a wheelchair (utilizing his/her feet) away from the table and had to be redirected by staff back to the table for lunch, three times before the resident's meal arrived. On 10/09/19 at 01:30 PM observed the resident in the hallway with Certified Nurse Aide(CNA)1. There were no foot rests on the resident's wheelchair, the CNA began to push the resident, then stopped and stated he/she would get R14's foot rests. The foot rests were retrieved from the resident's room, applied and R14 was wheeled (pushed) from the hall to the dining room. On 10/09/19 at 01:54 PM observed Staff Member (SM)1 wheeling R14 back to his/her room. There were no foot rests applied to the wheelchair, R14 had to lift his/her feet to prevent it from dragging on the ground. The resident's feet were barely off the ground. On 10/10/19 at 11:45 AM observed CNA2 pushing R14 from the resident's room to the dining area. The foot rests were not applied and the resident had to hold up his/her feet for the duration of the ride. CNA2 was asked whether R14 has foot rests, the CNA replied the foot rests are not applied as the resident wants to propel himself/herself about the unit. A record review found a quarterly Minimum Data Set with an assessment reference date of 08/05/19. R14 yielded a score of zero (severe	4 136	Effective 11/13/2019, all current residents who meet the following criteria: (1) using a wheelchair as their primary means of locomotion; (2) self-propel with the use of their hands and/or feet; and (3) score 13 or less on their BIMS (cognitive impairment) will have footrest attached to their wheelchairs. The footrest pedals will be in use if the resident needs assistance with transportation or if the resident requests assistance with transportation. This will allow the resident to rest their feet on the footrest and protect their feet from potential injury during transportation. On 11/7/2019 the IDT reviewed all residents who use wheelchairs as their primary means of locomotion without the use of footrest. The IDT reviewed each resident using a wheelchair and confirmed that footrest will be attached to all residents' wheelchairs if resident scores 13 or less on their BIMS and is identified with cognitive impairment. For residents not identified with cognitive impairment (14 or higher on BIMS), the resident's care plan will be updated to document that footrest will be applied for long distance travel for safety and can otherwise remain off per resident's preference. Effective 11/13/2019, all current and future residents who meet the following criteria: (1) using a wheelchair as their primary means of locomotion; (2) self-propel with the use of their hands and/or feet; and (3) score 13 or less on their BIMS (cognitive impairment) will have footrest attached to their wheelchairs. For residents not identified with cognitive impairment (14 or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125063	A. BUILDING: _____ B. WING _____	10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
15 CRAIGSIDE	15 CRAIGSIDE PLACE HONOLULU, HI 96817

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 136	Continued From page 2 cognitive impairment) upon administration of the Brief Interview for Mental Status. The resident was coded with signs and symptoms of delirium (fluctuating behavior, inattention, disorganized thinking and altered level of consciousness). R14 was also noted to have range of motion impairment of both lower extremities. A review of the care plan provided by the facility on the morning of 10/11/19 notes R14 is at risk for fall and injuries due to impaired safety judgment and generalized weakness (extensive to total assist with mobility). Also noted, R14 uses the wheelchair as the main mode of locomotion, he/she is able to wheel in the hallway with general supervision. R14 is documented to receive routine antipsychotic medication (risperdal). Further review found a "Care Plan Update Sheet" which notes an additional entry dated 10/09/19 with the following intervention: If staff is wheeling resident from resident's room to around dining area, foot rest is not needed as resident is able to propel but resident may need assistance in direction. If resident uses his/her feet as a brake to stop the wheelchair, staff will stop wheeling and ask resident what he/she would like to do. The update was recorded by the Director of Nursing (DON) on 10/11/19 at 08:24 AM after initial observations and interviews were done. On 10/11/19 at 09:52 AM an interview was conducted with the Physical Therapist (PT). The PT confirmed he/she is familiar with R14 and concurrent observation of the resident's wheelchair found the foot rests were not affixed to the chair. The PT reported the foot rests are not placed on the wheelchair to allow R14 to be mobile. The PT demonstrated that with the foot	4 136	higher on BIMS), the resident's care plan will be updated to document that a footrest will be applied for long distance travel for safety and can otherwise remain off per resident's preference. On 11/7/2019, staff were trained on wheelchair footrest usage and how to transport residents safely using the wheelchair. (Please see attached training and acknowledgement form.) Effective 11/13/2019 , ongoing monitoring of identified residents needing footrest on wheelchairs will be completed by CNA Manager and/or Designee. The CNA Manager/Designee will complete a footrest check log for each shift. The CNA Manager/Designee will be looking to ensure that residents identified as needing footrests, have footrests attached to their wheelchairs and that they are being used correctly. Findings from this audit will be reviewed and shared during facility's quality assurance program. (Please see attached footrest check log.)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125063	A. BUILDING: _____ B. WING _____	10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
15 CRAIGSIDE	15 CRAIGSIDE PLACE HONOLULU, HI 96817

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 136	Continued From page 3 rest applied, the foot rests can snap back and hit the resident's feet/legs while he/she is self-propelling. The PT was asked about staff members pushing the resident in the wheelchair without placing his/her feet on the foot rests. The PT reported R14 has a tendency to drop his/her feet down and for safety purposes foot rests are indicated.	4 136		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observation, inquiry with staff, and policy review, the facility failed to follow their protocol/procedure; where a kitchen staff member, (KSM) 1, failed to wear a hair restraint while in the kitchen. As a result of this deficient practice, the facility put the residents at risk for food contamination. Findings include: During a walk through of the kitchen on 10/09/19 at 08:35 AM, KSM1 was observed not wearing any hair restraint (such as a hat, or hair net) while	4 159	15 Craigside is committed to ensuring that residents remain safe and attain or maintain the highest practicable quality of life. On 11/14/2019, a review of the facilities Sanitation protocol was completed and training for the identified kitchen staff member was completed. Per protocol, dining services personnel are to wear appropriate clothing including hair restraints such as hats, hair coverings or net. (Please see attached revised	11/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125063	A. BUILDING: _____ B. WING _____	10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
15 CRAIGSIDE	15 CRAIGSIDE PLACE HONOLULU, HI 96817

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 159	Continued From page 4 being in the kitchen. When asked the reason why a hair restraint was not being used, KSM1 stated that he/she just came in recently from outside. The Kitchen Manager (KMgr), who accompanied the walk through, was queried about the above finding. KMgr acknowledged that KSM1 should have been wearing a hair restraint while being in the kitchen. KMgr also stated that it was in their Dining Protocols to wear hair restraints (such as a hat, or hair net). A review of facility's policy on Dining Protocols stated the following: Personal Hygiene; Dining Services personnel are to wear appropriate clothing including hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils and linens, and unwrapped single-service and single-use articles.	4 159	Sanitation protocol) On 11/14/2019 dining services staff were trained about the proper use of hair restraints such as hats, hair coverings or nets. Effective 11/14/2019, an additional hair net station will be added to the back entrance of the kitchen. This will provide an access of hair restraints in both the front and back entrances of kitchen. Dining services staff were trained on the location of the additional storage on 11/14/2019. (Please see attached Training form). Effective 11/14/2019, a monthly random hair restraint audit will be completed by Dietitian or Designee. The monthly audit will occur for 6 consecutive months and then will transition to a quarterly audit. Findings from this audit will be reviewed and shared during facility's quality assurance program. (Please see attached hair restraint compliance observation form).	
4 197	11-94.1-46(n) Pharmaceutical services (n) Discontinued and outdated prescriptions and containers with worn, illegible, or missing labels shall be disposed of according to facility policy. This Statute is not met as evidenced by: Based on observation and interview with staff members, the facility failed to control and account for controlled drugs while awaiting disposal, as	4 197	15 Craigside is committed to ensuring that residents remain safe and attain or maintain the highest practicable quality of	11/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125063	A. BUILDING: _____ B. WING _____	10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
15 CRAIGSIDE	15 CRAIGSIDE PLACE HONOLULU, HI 96817

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 197	Continued From page 5 evidenced by accurate documentation of medications placed in the locked drawer for disposal; multiple nurses having access to controlled drugs stored in a locked drawer; and a system to account for controlled medication disposal in sufficient detail to enable accurate reconciliation to prevent drug diversion. Findings include: On 10/10/19 at 12:05 PM, inspected the medication storage room with Registered Nurse (RN)1. Observation of the locked controlled drugs found a discrepancy between the list of medications and the actual medications. There were five medications in the drawer; however, only four were listed. An open bottle of Oxycodone HCL 100 mg/ 5 ml for Resident (R)13 was not documented on the "Medication to be Discarded" log. RN1 confirmed that the Oxycodone was not documented on the log. Although RN1 did not place the Oxycodone in the locker drawer, upon discovery of the undocumented medication, RN1 made an entry dated 10/10/19 with R13's name, type of medication, number of units remaining (11.4 ml) and initialed the entry. RN1 did not measure the Oxycodone prior to documenting the units remaining. Inquired about the process of discarding medication. RN1 responded medications that are removed from the medication cart, are then listed on the "Medications to be Discarded" log. Medications are stored for a week in the locked drawer, with disposal scheduled every Friday. The responsibility for discarding medications are rotated between the three shifts. The RN1 was asked who has access to the locked drawer, RN1 responded multiple staff have access to the	4 197	life. On 10/11/2019 the Director of Nursing (DON) reviewed all residents who have controlled substances stored for disposal. The DON determined that the controlled substances stored for disposal were properly documented on the Medication to be Discharged form and were destroyed per medication disposal and sharps disposal protocol on 10/11/2019. On 11/7/2019 the IDT reviewed the resident identified in the findings and confirmed that the controlled substance was disposed of on 10/11/2019. Licensed nurses followed medication disposal, sharps disposal (Please see attached), and Narcotics (Controlled Substance) protocols. Access to controlled substances are limited to the medication nurse in charge of their specific medication cart. Effective 10/22/2019, controlled substances are no longer stored in the medication room drawer, and instead will remain locked in a narcotic box inside the medication cart. On 10/11/2019 the DON reviewed all controlled substances stored for disposal and ensured that the medications to be discarded and individual controlled drug records were completed and accurate. Effective 10/22/2019, all controlled substances that are deemed to be destroyed (discontinued, expired and narcotic medications remaining after a resident expires) will be destroyed by end of shift and not stored for future disposal per revised Medication disposal and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125063	A. BUILDING: _____ B. WING _____	10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
15 CRAIGSIDE	15 CRAIGSIDE PLACE HONOLULU, HI 96817

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 197	Continued From page 6 drawer. During a day, there are up to five nursing staff that have access to the drawer (two medication nurses during the day shift; two medication nurses during the evening shift; and one mediation nurse during the night shift). The Director of Nursing confirmed that there are multiple staff that have access to the locked drawer. Further review of the "Medication to be Discarded" log for controlled drugs found there is no documentation of the time the drug was placed in the locked drawer. Also, there is no initial verification by another nurse to attest how many units/tablets remain when it is placed in the locked drawer for disposal purposes. Additionally, there is no way to identify who and when staff accessed the drawer.	4 197	sharps disposal protocol. Two Licensed Nurses will discard and sign off on the medication to be discarded form and controlled drug record. (Please see attached Medications to be discarded form and Controlled drug record). Starting 10/22/2019 all controlled substances that are deemed for disposal will be disposed by end of shift and not stored for future disposal. Two Licensed Nurses will discard and sign off on the medication to be discarded form and controlled drug record. (Please see attached Medications to be discarded form and Controlled drug record). On 10/22/2019 all Licensed Nurses were trained on the updated Medication/sharps disposal protocol and Narcotics (Controlled substance) Protocol. (Please see attached training acknowledgment forms. Effective 10/22/2019,the Narcotic box inside of the medication carts will be randomly audited once per week by DON or Designee. This will ensure that controlled substances are not being stored inappropriately per facility protocol. Findings from this audit will be reviewed and shared during facility□s quality assurance program. (Please see attached controlled substance audit form).	